IDAHO DEPARTMENT OF
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August 24, 2006

Melinda Saville, Administrator
Ashley Manor - Hawthorne, Ashley Manor, LLC
4826 Hawthorne Road
Chubbuck, ID 83202

Dear Ms. Saville:

On June 29, 2006, a complaint investigation survey was conducted at Ashley Manor - Hawthorne, Ashley Manor, LLC. The survey was conducted by Rae Jean McPhillips, R.N., and Debra Sholley, L.S.W. This report outlines the findings of our investigation.

Complaint #ID00001512

Allegation #1: An identified resident eloped from the facility on June 3, 2006 by going out her bedroom window. The facility was not aware that the resident had left the facility until she was returned to the facility by the public.

Findings: Based on interview and record review, it could not be determined that the identified resident eloped from the facility's premises on June 3, 2006.

On June 29, 2006 at 11:30 a.m., the facility's house manager confirmed that the identified resident had climbed out of her bedroom window on June 3, 2006 into an unfenced backyard. She stated that the facility was called by a neighbor who reported that the resident was out in the backyard by the facility's storage shed. Additionally, the house manager said that the resident had not sustained any injury while she was outside of the building.

On June 26, 2006 at 11:45 a.m., a review of the facility's accident and incident reports revealed that a report dated June 5, 2006 documented the resident had left the building through her bedroom window on June 3, 2006. The report further documented that an outside source had called the facility and advised them the resident was outside by the storage shed.

Conclusion: Unsubstantiated. Although the allegation may have occurred, there was not enough evidence to prove that the resident had left the facilty premises on June 3, 2006. Therefore, according to IDAPA 16.03.22.011.10.c, it could not be demonstrated that the resident eloped from the facility.

Allegation #2: The facility failed to complete an incident report for the event described in Allegation #1.

Findings: Based on record review, it was determined that the facility did complete an incident report for the event described in Allegation #1.

Review of the facility's incident and accident reports on June 29, 2006 revealed an incident report dated June 5, 2006 documenting that the identified resident had left the building on June 3, 2006.

Conclusion: Unsubstantiated. The facility did complete an incident report that documented the identified resident had left the building on June 3, 2006.

Allegation #3: The facility failed to report the event described in Allegation #1 to the Commission on Aging.

Findings: Based on interview and record review, it could not be determined that the identified resident eloped from the facility premises on June 3, 2006.

On June 29, 2006 at 11:30 a.m., the facility's house manager stated that the resident was still on the facility premises when they were notified by the public that the resident was alone in the unfenced portion of the backyard.

Review of the facility's incident reports on June 25, 2006 revealed an incident report dated June 5, 2006 that documented the resident was in the backyard by the shed. There was no documentation that indicated the resident left the facility premises on June 3, 2006.

Conclusion #3: Unsubstantiated. As it was determined that the event described in Allegation #1 was not considered an elopement, it was not necessary for the facility to report it to the Commission on Aging.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

/s/ for

DEBBIE SHOLLEY, L.S.W.
Team Leader
Health Facility Surveyor
Residential Community Care Program

DS/sm

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program